LIFE / AD&D INFORMANT'S FORM

EMPLOYEE INFORMATION

Name: _____
SS#: _____
Job Title: _____
Original Date of Hire: _____
Last Payroll Deduction: _____
Date Last Worked: _____

DECEASED OR DISMEMBERED PERSON'S INFORMATION

Name: _____
SS#: _____
Date of Birth: _____
Date of Death or Dismembering Accident: _____
Was the death or dismemberment the result of an accident? ◯ Yes ◯ No

CONTACT PERSON'S INFORMATION

Name (beneficiary or estate administrator): _____
Street Address: _____ Phone: _____
City: _____ State: _____ ZIP Code: _____

COVERAGE AMOUNTS

Employee Basic Life:	$ _____	Coverage Effective Date:	_____
Employee Optional Life:	$ _____	Coverage Effective Date:	_____
Spouse Optional Life:	$ _____	Coverage Effective Date:	_____
Dependent Optional Life:	$ _____	Coverage Effective Date:	_____

AGENCY INFORMATION

Payroll/Personnel Administrator's Name: _____
Org ID: _____
Tel. No. _____

INSTRUCTIONS

1. When informed of the death or accidental dismemberment of an employee, spouse, or dependent child, complete as many of the above items as possible.
2. FAX the following forms to Employee Benefits within 48 hours of the notice of death:
   a. The original Life & AD&D Insurance Enrollment & Change Form showing the coverage level signed-off by carrier.
   b. The most recent Life & AD&D Insurance Enrollment & Change Form with most recent beneficiary designation(s).

Employee Benefits:
FAX: 303-866-3879
Voice: 1-800-719-3434 or 303-866-3434

REMARKS